STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155364	B. WING		11/09/2012
NAME OF F	ROVIDER OR SUPPLIE	R		Γ ADDRESS, CITY, STATE, ZIP CODE	
DVD ON I	IEAL TH OFNITED			LIMA RD	
BYRON	HEALTH CENTER		FORT	WAYNE, IN 46818	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG K0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	BELLEHALT	DATE
ROOOU					
	A Life Safety C	Code Recertification,	K0000		
	State Licensur			This Plan of Correction is the	
		lk-thru Survey were		Center's credible allegation of	
		the Indiana State		compliance. Preparation and/or	
	Department of			execution of this plan of correction	
	<u> </u>	th 42 CFR 483.70(a).		does not constitute admission or agreement by the provider of the	
	accordance Wi	11 12 CI (\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		truth of the facts alleged or	
	Survey Date:	11/08/12 and		conclusions set forth in the state	
	11/09/12	11/06/12 and		deficiencies. The plan of correction	1
	11/09/12			is prepared and/or executed	
	Fa ailie - Nicceale e	000355		because the provisions of federal	
	Facility Number			and state law require it.	
	Provider Numb				
	AIM Number:	100273280			
	6	Kalla Life Cafee			
		y Kelley, Life Safety			
	Code Specialis	ST.			
	A LUCE LUCE CE	for Code on a			
		fety Code survey,			
		Center was found			
	not in complia				
	-	for Participation in			
	Medicare/Med	,			
	•	0(a), Life Safety			
		the 2000 edition of			
	the National Fi	ire Protection			
		IFPA) 101, Life Safety			
	Code (LSC), Ch	napter 19, Existing			
		ccupancies and 410			
	IAC 16.2.				
	This four story	y facility with a			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155364	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE S COMPL 11/09/	ETED		
	PROVIDER OR SUPPLIER HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODE	D BE	(X5) COMPLETION DATE		
	basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and areas open to the corridors. Battery operated smoke detectors have been installed in all resident rooms. The facility has a capacity of 191 and had a census of 111 at the time of this survey. The facility was found not in compliance with state law in regard to sprinkler coverage and found in compliance with state law in regard to smoke detector coverage. All areas where the residents have customary access were sprinklered, except the Friendship Corner elevator vestibule. Areas providing facility services which were not sprinklered were the 4 elevator equipment rooms, the lower level generator room, the biohazard storage room, 1 elevator storage room and the old pharmacy sump pump room. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/19/12.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Q42521

Facility ID: 000255

If continuation sheet

Page 2 of 18

PRINTED: 12/12/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 155364	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMI	e survey pleted 9/2012		
	PROVIDER OR SUPPLIER HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Q42521

Facility ID: 000255

If continuation sheet

Page 3 of 18

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	IA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	01	COMPL	ETED
		155364	B. WIN			11/09/	2012
			1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			12101 L	IMA RD		
BYRON H	HEALTH CENTER			FORT V	VAYNE, IN 46818		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T	ſΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0018 SS=D	NFPA 101 LIFE SAFETY CO	ODE STANDARD					
33-0		corridor openings in other					
		closures of vertical					
	openings, exits, o	r hazardous areas are					
		, such as those constructed					
		onded core wood, or					
		ng fire for at least 20 n sprinklered buildings are					
		esist the passage of					
		no impediment to the					
		ors. Doors are provided					
		able for keeping the door					
	permitted. 19.3	ors meeting 19.3.6.3.6 are					
	permitted. 19.5	5.0.3					
		prohibited by CMS					
	_	health care facilities.	17.00	110			12/00/2012
	1. Based on ob		K00)18	K018 NFPA 101 Life Safety		12/09/2012
	interview, the f				Code Standards What corrective action(s) will be		
		estroom corridor			accomplished for those		
	doors in Sectio				residents found to have been	i	
		e door frame. This			affected by the deficient		
	=	ce was not in a			practice. 1) Latching hardwa was installed on the door. This		
		rea but could affect			area is not inhabited by reside	_	
	any number of	staff.			and access to the area is very		
					limited with staff as well. 2) A		
	Finding include	2:			furniture, beds, wheelchairs, a general storage items have be		
					removed from the room corrido		
		rvation with the			exits. This area is not inhabite	:d	
	Director of Plar	nt Operations on			by residents and access to the		
	11/09/12 at 11	1:36 a.m., the			area is very limited with staff a	S	
	corridor door t	o the Section 1			well. How other residents having the potential to be		
	restroom lacke	d latching hardware			affect by the same deficient		
	and did not late	ch into the door			practice will be identified and		
	frame. Section	1 is currently			what corrective action(s) will		
	closed and the	restroom is being			be taken. 1) No resident has	the	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Q42521

Facility ID: 000255

If continuation sheet Page 4 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	01	COMPLETED
		155364	B. WIN			11/09/2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	8			IMA RD	
BYRON I	HEALTH CENTER				WAYNE, IN 46818	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	used for storag	ge of over the bed			potential to be affected by the	
	tables. This w	as acknowledged by			practice. This area is closed to	II
		Plant Operations at			resident, guests, and visitors.	
	the time of obs	·			No resident has the potential to be affected by the practice. The	
	the time of obs	servation.			area is closed to resident, gue	
	3.1–19(b)				and visitors. What measures	,
					will be put into place or what	
					systemic changes will be ma	de
	2. Based on ol	oservation and			to ensure that the deficient	
	interview, the f	facility failed to			practice does not recur. 1)	
	ensure there w	ere no impediments			The latch has been changed a	I
	to the closing (of 9 of 12 resident			therefore will not recur. 2) All maintenance staff will be	
	_	doors in Section 1.			in-serviced as to the proper wa	av
		practice was not in a			to store items in the closed uni	-
	-				ensure general storage items	do
		rea but could affect			not block the corridor exits. He	ow
	any number of	staff.			the corrective action(s) will b	e
					monitored to ensure the	
	Findings includ	de:			deficient practice will not rec	ur
					i.e., what quality assurance	
	Based on obse	rvations with the			program will be put into place The Director of Plant Operation	
	Director of Plai	nt Operations on			or his designee, will monitor th	-
	11/09/12 at 1	•			closed unit monthly for items the	
	corridor doors				might have been placed in	
					corridor exit paths. Please see	
		t rooms in Section 1			attachment #1. The audits will	lbe
	were obstructe	•			reviewed monthly at the QA	
		airs and general			meeting. This monitoring will occur for nine months. By wh	at
	storage preven	iting the doors from			date the systemic changes w	II
	closing and lat	ching into the door			be completed. December 9,	
	frame. Section	1 is currently			2012	
		resident rooms are				
		storage. This was				
	_	by the Director of				
ı	_	•				
	•	ns at the time of				
	observations.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Q42521

Facility ID: 000255

If continuation sheet

Page 5 of 18

PRINTED: 12/12/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155364	(X2) MULTIPLE CO A. BUILDING B. WING	01		E SURVEY LETED 9/2012		
NAME OF F	PROVIDER OR SUPPLIEF	R		ADDRESS, CITY, STATE, ZIP CO	ODE			
BYRON I	HEALTH CENTER		12101 LIMA RD FORT WAYNE, IN 46818					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	3.1-19(b)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Q42521

Facility ID: 000255

If continuation sheet

Page 6 of 18

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ĺ	ULTIPLE CO LDING	ONSTRUCTION 01	(X3) DATE : COMPL	
		155364	B. WIN			11/09/	2012
	PROVIDER OR SUPPLIER		•	12101 L	ADDRESS, CITY, STATE, ZIP CODE LIMA RD NAYNE, IN 46818	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0029 SS=E	NFPA 101 LIFE SAFETY CO One hour fire rate hour fire-rated do automatic fire exti accordance with 8 protects hazardou approved automa system option is u separated from of resisting partitions self-closing and in protective plates of inches from the b permitted. 19.3 Based on obser interview, the fi ensure the corr trash collection rooms was pro closing device. practice could of residents. Findings include Based on obser Director of Plan 11/09/12 at 10 closing devices on the corridor labeled waste/ three trash bar biohazard barr collection of trash	DDE STANDARD ad construction (with 34 ors) or an approved inguishing system in 3.4.1 and/or 19.3.5.4 as areas. When the tic fire extinguishing used, the areas are ther spaces by smoke and doors. Doors are on-rated or field-applied that do not exceed 48 ottom of the door are .2.1 evation and acility failed to ridor door to 1 of 1 a/biohazard storage vided with a self. This deficient affect five first floor The operations on 0.49 a.m., a self was not provided to the room pump room with rels and one el used for the	K00	029	K 029 NFPA 101 Life Safety Code Standards What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. A self-closing device was installed of the corridor door to the room labeled waste/pump room. How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by the door not having a self-closing device. What measures will be put into place or what systemic changes will be made to ensure that the	n e	12/09/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Q42521

Facility ID: 000255

If continuation sheet

Page 7 of 18

PRINTED: 12/12/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155364	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMP 11/09	E SURVEY LETED 0/2012
BYRON	PROVIDER OR SUPPLIEF		12101	ADDRESS, CITY, STATE, ZIP C LIMA RD WAYNE, IN 46818	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	acknowledged	by the Director of ns at the time of		deficient practice does no The systemic change was to self-closing device has been and will remain on the door to the corrective action monitored to ensure the correctice will not recur i.e., quality assurance program put into place. The Director of Plant Oper his designee, will monitor closing device monthly to proper functioning of the correction of the QA meeting. This monitor will occur for nine months. By what date the systemic will be completed. Decem 2012	chat the in installed or. (s) will be deficient, what in will be ations, or the self ensure device. The onthly at attoring in changes	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Q42521

Facility ID: 000255

If continuation sheet

Page 8 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	a. building 01 Completed			ETED	
		155364	B. WIN			11/09/	2012
			D. (// II (ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				IMA RD		
BYRON H	HEALTH CENTER				WAYNE, IN 46818		
		TA TEN CENTE OF DEPENDING	1				Q15)
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	ΓE	DATE
K0038	NFPA 101	ESC IDENTIFY TING INFORMATION)		IAG			DATE
SS=E	LIFE SAFETY CO	DDF STANDARD					
00-L		anged so that exits are					
		e at all times in accordance					
	with section 7.1.	19.2.1					
	Based on obser	vation and	K00	38			12/09/2012
	interview, the f	acility failed to			K 038 NFPA 101 Life Safety Code		
	ensure 2 of 18	•			<u>Standards</u>		
		provide adequate					
	· ·	·			What corrective action(s) will be		
		C 7.1.5 requires the			accomplished for those residents		
	•	ss shall be designed			found to have been affected by the deficient practice.		
	and maintained	•			dencient practice.		
	adequate head	room as provided in			The cited corridors are not corridors	;	
	other sections	of this Code and			resident are required to use and are		
	shall not be les	s than 7 feet 6			not part of corridors for egress from	l	
	inches with pro	jections from the			the building. This facility has been		
	ceiling not less	*			granted a waiver for many years and	t	
	~	height above the			we will once again request the		
	finished floor.				waiver.		
		shall be maintained			How other residents having the		
		in two thirds of the			potential to be affect by the same		
	ceiling area of	any room or space,			deficient practice will be identified and what corrective action(s) will		
	provided the ce	eiling height of			be taken.		
	remaining ceili	ng area is not less			be taken.		
	than 6 feet 8 in	nches. This			The ceiling heights have been this		
		ce could affect any			ways for decades and no resident		
		and visitors in the			has been adversely affected.		
		nese two basement					
		iese two paseillellt			What measures will be put into		
	corridors.				place or what systemic changes wil	I	
					be made to ensure that the		
	Findings includ	le:			deficient practice does not recur.		
					The ceiling area cited is in the		
	Based on obser	vations on			basement area and was built in the		
	11/08/12 from	n 12:20 p.m. to			1920's There is no economically		
		•					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Q42521

Facility ID: 000255

If continuation sheet Page 9 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 01			(X3) DATE S COMPLI		
AND PLAN	OF CORRECTION	155364	A. BUI	LDING	U1 	11/09/	
		155504	B. WIN			11/09/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
BADUN I	HEALTH CENTER				LIMA RD VAYNE, IN 46818		
					VATNE, IN 40010	ı	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		11/09/12 from			feasible way to raise the ceiling		BIIIE
	•	2:00 p.m. with the			height. The useful life of the		
		nt Operations, the			building is only 3 -5 years.		
	_	s in the basement			How the corrective action(s) will be	е	
	failed to provid	ie adequate			monitored to ensure the deficient practice will not recur i.e., what		
	headroom:	منا خمام ما المماليم عمر			quality assurance program will be		
		ent ceiling height in			put into place.		
		corridor measured					
	six feet two and one half inches. Additionally, there was a pipe protruding below the ceiling along				We will be requesting a waiver.		
					Please see attachment #3.		
					By what date the systemic changes	;	
	the 70 foot corridor that measured				will be completed. December 9,		
		inches from the			2012		
		s acknowledged by					
		Plant Operations at					
	the time of obs						
	_	height at the south					
		idor smoke barrier					
	wall measured						
		onally, there was a					
		g below the ceiling					
	which ran alon	g the center					
		idor that measured					
	six feet from th	ne floor and the					
	north-south co	orridor intersection					
	had pipes prot	ruding below the					
	ceiling which r	an along the					
		neasure five feet					
	nine inches fro	m the floor. This					
	was acknowled	lged by the Director					
	of Plant Operat	tions at the time of					
	observations.						
			1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Q42521

Facility ID: 000255

If continuation sheet

Page 10 of 18

PRINTED: 12/12/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155364	(X2) MULTIPLE CO A. BUILDING B. WING	01	COM 11/0	TE SURVEY IPLETED 19/2012	
BYRON	PROVIDER OR SUPPLIE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	CCTION ULD BE PROPRIATE	(X5) COMPLETION DATE	
	3.1-19(b)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Q42521

Facility ID: 000255

If continuation sheet

Page 11 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155364			ULTIPLE CO LDING	01	(X3) DATE : COMPL	ETED	
		155364	B. WIN			11/09/	2012
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE LIMA RD		
BYRON I	HEALTH CENTER			FORT V	VAYNE, IN 46818		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0056 SS=E	installed in accord Standard for the I Systems, to provi all portions of the properly maintain NFPA 25, Standa Testing, and Mair Fire Protection Sysupervised. Ther water supply for the sprinkler systems flow and tamper selectrically connected alarm system. Based on observite the following and tamper selectrically connected alarm system. Based on observite the following sprinkler systems for the following sprinkler system	matic sprinkler system, it is dance with NFPA 13, nstallation of Sprinkler de complete coverage for building. The system is ed in accordance with rd for the Inspection, ntenance of Water-Based vstems. It is fully e is a reliable, adequate the system. Required are equipped with water switches, which are cted to the building fire 19.3.5 evation and facility failed to olete automatic m was provided for equipment rooms, room, 1 of 2 ins, 1 of 1 old p pump rooms and ip Corner elevator in accordance with lard for the sprinkler Systems, plete coverage for the building. This ce was not in a rea but could affect exception of the mer lounge with a	K00	056	K 056 NFPA 101 Life Safety Code Standards What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Bids have been obtained and signed. The work has been scheduled and the sprinkler system will be installed. How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by the lack of sprinklers in the identified areas.	s	12/09/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Q42521

Facility ID: 000255

If continuation sheet

Page 12 of 18

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	PPLIER/CLIA (X2) MU		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LDING	01	COMPLETED	
		155364	B. WIN		-	11/09/2012	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				12101 L	_IMA RD		
BYRON HEALTH CENTER					WAYNE, IN 46818		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	DATE	
	Findings include:				What measures will be put into		
				place or what systemic changes wi		I	
	Based on obse	rvations with the			be made to ensure that the deficient practice does not recur.		
	Director of Plai	nt Operations on			dencient practice does not recui.		
	11/08/18 from	n 12:20 p.m. to			A bid has been obtained for		
	1:33 p.m. and	11/09/12 at 11:16			installing sprinklers in the cited		
	p.m., the follow	wing areas lacked			areas. The work will be scheduled		
	sprinkler cover				and completed as quickly as the		
	=				contractor can accomplish the work		
	a. Lower level elevator # 4 equipment room and storage room b. Lower level elevator equipment room for the freight elevator c. Lower level elevator # 6 equipment room d. Lower level generator/boiler				needed.		
					How the corrective action(s) will be	,	
					monitored to ensure the deficient		
					practice will not recur i.e., what		
					quality assurance program will be		
					put into place.		
					Once the sprinkler systems are		
	room				installed, the corrective action has		
	e. Lower level l	oiohazard storage			been completed. It will then become part of system wide		
	room f. First floor old pharmacy sump pump room g. Pent house elevator equipment room h. Friendship Corner elevator vestibule area Based on an interview with the Director of Plant Operations at the time of observations, he was aware of this requirement and has contacted a sprinkler company for an estimate.				sprinkler testing program conducted	1	
					by an outside vendor as required by		
					law. Please see attachment #4		
					By what date the systemic changes		
					will be completed. December 9,		
					2012		
	3.1-19(b)						
3.1 13(8)					1		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Q42521

Facility ID: 000255

If continuation sheet

Page 13 of 18

PRINTED: 12/12/2012 FORM APPROVED OMB NO. 0938-0391

		(X2) MULTIPLE CO	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	01	COMPLETED	
		155364	B. WING		11/09/2012
NAME OF F	PROVIDER OR SUPPLIER	3		ADDRESS, CITY, STATE, ZIP CODE	
		•		LIMA RD	
BYRON	HEALTH CENTER		FORT \	WAYNE, IN 46818	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	3.1-19(ff)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Q42521

Facility ID: 000255

If continuation sheet Page 14 of 18

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	JIA X2) MULTIPLE CONSTRUCTION X3) DATE SUR			SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 01 CC		COMPL	COMPLETED	
155364		155364	B. WIN			11/09/	2012
			B. ((11)	_	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				IMA RD		
BYRON HEALTH CENTER					VAYNE, IN 46818		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID				(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)			CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE	DATE
K0143	NFPA 101					-	
SS=E	LIFE SAFETY CODE STANDARD						
	Transferring of ox	kygen is:					
	(a) senarated from	m any portion of a facility					
		are housed, examined, or					
		ration of a fire barrier of					
	1-hour fire-resistiv						
	(b) in an area that	t is mechanically ventilated,					
		nas ceramic or concrete					
	flooring; and						
	(c) in an area pos	sted with signs indicating					
that transferring is occurring, and that							
	•	mediate area is not					
	permitted in accordance with NFPA 99 and the Compressed Gas Association.						
	8.6.2.5.2	Gas Association.					
	Based on observation and		K0143		K 143 NFPA 101 Life Safety		12/09/2012
	interview, the f	acility failed to			Code Standards What		
	ensure 3 of 3 areas used for				corrective action(s) will be accomplished for those		
	transferring of	oxygen were			residents found to have beer	1	
	separated from	any portion of a			affected by the deficient		
	facility wherein	residents are			practice. A bid has been obta		
	housed, exami	ned, or treated by a			to purchase new doors for the three areas identified. The		
	separation of a	fire barrier of 1			installation of the doors will		
	hour fire resist	ive construction.			depend on the delivery date of	f the	
	This deficient p	oractice could affect			doors to the vendor. Please s	ee	
	22 residents.				attachment #5. How other		
3212121321					residents having the potentia	AI .	
	Findings includ	le:			to be affect by the same deficient practice will be		
	J • • • •				identified and what correctiv	е	
	Based on an ob	servation with the			action(s) will be taken. All	h a	
	Director of Plar	nt Operations on			residents have the potential to affected by this deficient pract		
		:33 p.m. and on			What measures will be put in		
		1:02 p.m. and then			place or what systemic		
	,,				·		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Q42521

Facility ID: 000255

If continuation sheet

Page 15 of 18

PRINTED: 12/12/2012 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 155364	A. BUILDING B. WING	(X3) DATE S COMPLI	ETED
	PROVIDER OR SUPPLIER HEALTH CENTER	STREET ADDRESS, CITY, 12101 LIMA RD FORT WAYNE, IN 4		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRI CROSS-REFER	ER'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE EENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	again at 1:07 p.m., the first, second and third floor oxygen storage/transfilling rooms had an unrated metal door. Each room contained one or more large liquid oxygen cylinders. Based on an interview with the Director of Plant Operations at the time of observations, he was unable to verify the fire rating of the door to the oxygen storage/transfilling rooms. 3.1–19(b)	ensure that practice do the doors he the systemic completed. action(s) we ensure the will not recessurance into place. been replace permanent and monitor take place. systemic c	ill be made to t the deficient bes not recur. Once ave been replaced, c change will be How the corrective fill be monitored to deficient practice fur i.e., what quality program will be put Once the doors have fied, there will be a solution to the issue fring will not need to By what date the hanges will be December 9, 2012	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Q42521

Facility ID: 000255

If continuation sheet

Page 16 of 18

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTI		IDENTIFICATION NUMBER:	A PULL DING 01		01	COMPLETED	
155364		A. BUILDING B. WING			11/09/	2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
DVDON HEALTH OFNIED					IMA RD		
BIRUNI	BYRON HEALTH CENTER			FURI	WAYNE, IN 46818		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0147	NFPA 101						
SS=D	LIFE SAFETY CO						
	_	and equipment is in					
		NFPA 70, National					
	Electrical Code. 9						10000
	Based on obse		K01	4'/			12/09/2012
	interview, the f	acility failed to			K 147 NFPA 101 Life Safety Code		
	ensure 2 of 2 f	lexible cords such			<u>Standards</u>		
	as an extension	n cord were not			What corrective action(s) will be		
	used as a subs				What corrective action(s) will be accomplished for those residents		
					found to have been affected by the		
	wiring. LSC 9.	•			deficient practice.		
	electrical wiring and equipment to			dencient practice.			
	comply with NFPA 70, National				1) The extension cords have		
	Electrical Code	, 1999 Edition.			been removed from the Nurse		
	NFPA 70. Articl	le 400-8 requires,			Supervisor Office.		
	unless specific	•					
	flexible cords and cables shall not				2) The heavy weight extension		
					cord has been removed and		
	be used as a substitute for fixed				replaced with conduit in the		
	wiring of a structure. This				maintenance workshop.		
	deficient practi	ice was not in a					
	resident care area but could affect				How other residents having the		
	staff.				potential to be affect by the same		
	Starri				deficient practice will be identified		
	er ir i i i	J.,			and what corrective action(s) will		
	Findings include:				be taken.		
					l		
	Based on an ob	servation with the			All residents have the potential to b		
	Director of Plan	nt Operations on			affected by these deficient practices	i.	
	11/09/12 betw	veen 11:09 a.m. and			What measures will be muching.		
		egular light weight			What measures will be put into		
	· ·				place or what systemic changes will	1	
		was plugged in to			be made to ensure that the deficient practice does not recur.		
	_	eight extension			dendent practice does not recur.		
	cord and provi	ding power for the			1) The pencil sharpener was		
	pencil sharpen	er in the Nursing			relocated closer to an outlet so an		
	-	fice and a regular			extension cord is no longer needed.		
	25pc. 11501 5 01	and a regular			extension cord is no longer needed.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Q42521

Facility ID: 000255

If continuation sheet Page 17 of 18

PRINTED: 12/12/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155364	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED - 11/09/2012			
NAME OF PROVIDER OR SUPPLIER BYRON HEALTH CENTER			B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION			
	providing power the maintenan This was acknown Director of Plan time of observ	owledged by the nt Operations at the		2) A permanent power s has been added to the main workshop to an extension co no longer be needed. How the corrective action(s monitored to ensure the de practice will not recur i.e., v	tenance ord will) will be ficient			
	3.1-19(b)			quality assurance program of put into place. The Director of Plant Operath his designee, will monitor the building for improper use of extension cords. Please see attachment #6. The audits of reviewed monthly at the QA meeting. This monitoring wifor nine months. By what date the systemic community will be completed. December 2012	vill be ions, or e vill be iill occur			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Q42521

Facility ID: 000255

If continuation sheet

Page 18 of 18